VERMONT

www.labor.vermont.gov

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION
National Life Building, Drawer 20
Montpelier, VT 05620-3401

DEPT. USE ONLY Rev. 5/05

Cert. No. _____
Date Issued _____
Date Renewed _____
Date Suspended _____

APPLICATION FOR VERMONT CERTIFICATION
as a VOCATIONAL REHABILITATION COUNSELOR or INTERN

Please review the Vermont Department of Labor, Workers' Compensation Division, Rules and Regulations before proceeding.

1. Name _____
Last *Maiden* *First* *Middle Initial*

2. Address _____
Street *City* *State* *Zip Code*

3. Home Phone No. _____ Work Phone No. _____

4. Date of Birth _____ Social Security No. _____

5. E-mail Address: _____

6. Employer Name _____

7. Employer Address _____
Street *City* *State* *Zip Code*

8. Employer Phone No. _____

9. List any Licensure or Certification you currently hold.

_____

10. I am applying for certification as: ☐ Vocational Rehabilitation Counselor ☐ Vocational Rehabilitation Intern

11. I have previously applied to this office for certification as a _____ on _____

12. Have you ever been fined, convicted or charged for any violation of the law? If yes, please attach additional paper and describe fully.
☐ No ☐ Yes (Attach Additional Information)

EDUCATION

Bachelor's Degree ☐ Yes ☐ No Official transcript attached ☐ Yes ☐ No

College _____ Degree Received _____

Master's Degree ☐ Yes ☐ No Official transcript attached ☐ Yes ☐ No

College _____ Degree Received _____

Other Academic or Professional Certification Programs

Name	Dates Attended	Certificates Awarded

HISTORY OF PROFESSIONAL EXPERIENCE

List only those work experiences that meet the criteria of appropriate experience as defined by the Vermont Department of Labor, Workers' Compensation Division, Rules and Regulations. Start with your most recent experience. **Attach a signed statement from employer (per Rule 31.0400).**

Employer _____

Address _____

Date of Employment: From _____ To _____
Month / Day / Year *Month / Day / Year*

Job Title _____ Supervisor _____

Number of hours worked weekly _____ Paid position? ☐ Yes ☐ No

Describe work activities (attach additional sheets if necessary):

Employer _____

Address _____

Date of Employment: From _____ To _____
Month / Day / Year *Month / Day / Year*

Job Title _____ Supervisor _____

Number of hours worked weekly _____ Was this a paid position? ☐ Yes ☐ No

Describe work activities (attach additional sheets if necessary):

The applicant, by signing this application, hereby attests:

(1) The Department of Labor is authorized to verify any information on this application. I understand that a misrepresentation may result in rejection of my application or revocation of my certification.

(2) I agree to promptly submit any information requested for registration or monitoring purposes.

(3) I agree to attend training sessions sponsored by the Department of Labor, Workers' Compensation Division, as required by the Rules.

Signed: _____ Date: _____